DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 99-017

2. STATE: Kansas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
10/1/99

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.252

7. FEDERAL BUDGET IMPACT:
a. FFY 2000 $ 0
b. FFY 2001 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A Pages 26-32

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A Pages 26-32

10. SUBJECT OF AMENDMENT:
Methods and standards for establishing payment rates - Inpatient hospital care

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Janet Schalansky is the Governor's Designe

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Janet Schalansky

13. TYPED NAME:
Janet Schalansky

14. TITLE:
Secretary

15. DATE SUBMITTED:
12/28/99

16. RETURN TO:
Janet Schalansky
6th Floor North
915 SW Harrison
Topeka KS 66612

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
12/29/99

18. DATE APPROVED:
JUN 06 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
OCT 01 1999

20. SIGNATURE OF REGIONAL OFFICIAL:
Thomas W Lenz

21. TYPED NAME:
Thomas W. Lenz

22. TITLE:
ARA for Medicaid and State Operations

23. REMARKS:
Schalansky
Day
Haverkamp

SPA CONTROL

Date Submitted 12/28/99
Date Received 12/29/99

FORM HCFA-179 (07-92)

Instructions on Back

Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

5.0000 Reimbursement for NF Services (Swing Beds) in General Hospitals

Reimbursement for NF services (swing beds) provided in general hospitals (swing bed hospitals) shall be pursuant to 42 CFR 447.280.

6.0000 Disproportionate Share Payment Adjustment

The Medical Assistance Program (Medicaid/MediKan) of the State of Kansas shall make a reimbursement adjustment for disproportionate share hospitals. The reimbursement adjustment for disproportionate share hospitals shall be made for hospitals eligible under either criteria contained in 6.1000 or 6.2000 below.

Hospitals to be eligible under either Option 1 or Option 2 must have at least 2 obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services under the State Plan, except where the hospital serves predominantly individuals under 18 years of age, or where non-emergency obstetric services to the general population were not offered as of July 1, 1988. In rural areas the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. Please see section 6.50000 for addition instructions.

6.1000 Option 1

If determined eligible for disproportionate share payment adjustment according to P.L. 100-203, Section 4112, Subsection (b)(1)(A), and the Medicare Catastrophic Coverage Act, (eligibility shall be determined for a maximum of one year per determination), a hospital shall be reimbursed for disproportionate share according to the following. The mean Medicaid/MediKan inpatient utilization rate for Kansas hospitals receiving Medicaid/MediKan payments plus one standard deviation shall be subtracted from each hospital's Medicaid/MediKan inpatient utilization rate. If the remainder is greater than zero, the remainder shall be divided by 2, 2.5% shall be added, and the result shall represent the percentage payment adjustment. This percentage payment adjustment shall be multiplied by the Kansas Medicaid/MediKan annual payment for inpatient hospital services made for the state fiscal year ending two years prior to the year of the administration of a disproportionate payment adjustment. For example, 1995 state fiscal year payment adjustment shall be based upon the state fiscal year 1993 Kansas Medicaid/MediKan annual payment. The mean Medicaid/Medikan inpatient utilization rate shall include Medicare days paid by Medicaid. In order to be eligible, the hospital must have a minimum medical utilization of 1%, as determined in Option 1. Medicaid/MediKan utilization shall be based upon the Medicare cost report which must be available as of the start of the state fiscal year for which payments are to be made.

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6.2000 Option 2

Hospitals are determined to be eligible under the low-income utilization rate if, based upon the computations below, line C1 exceeds 25%. Hospitals shall be sent a form specifying the eligibility criteria prior to the start of each state fiscal year. Eligibility shall be determined for a maximum of one year per determination. Only hospitals returning the form may be potentially eligible for Option 2. This form shall be compared with the Medicare cost report (HCFA-2552-92), paid Medicaid/MediKan claims summary and other information as necessary in order to verify the data submitted. **The Medicare cost report must be available no later than the start of the state fiscal year for which payments are being made.**

All data below, except where specifically noted, should only include inpatient hospital data. SNF, ICF, long term care units, home health agency, swing bed, ambulance, durable medical equipment, CORF, ambulatory surgical center, hospice, rural health clinic, or non-reimbursable cost centers shall not be considered. Although specific references are given to the Medicare cost report, other line numbers may also be applicable where the hospital uses a blank line and adds an alternative title to the forms.

A1. Medicaid/MediKan inpatient payments for the most recent available hospital fiscal year, excluding disproportionate share payments.

A2 & A3. Other state and local government income from Medicare Worksheet G-3, Governmental appropriations (Line 23), excluding Disproportionate share payments.

A4. Total Medicaid/MediKan, State and local government funds (A1+A2+A3).

A5. Inpatient Revenues from Medicare worksheet G-2, Column 1, Total inpatient routine care services (line 16) + ancillary (line 17) + outpatient (line 18) - swing bed (lines 4 & 5) - SNF (line 6) - ICF (line 7) - LTCU (line 8).

A6. Total patient revenues from Medicare Worksheet G-2, Column 3 (line 25).

A7. Ratio of inpatient revenues to total patient revenues (A5 / A6).

A8. Contractual allowances and discounts from Medicare Worksheet G-3 (line 2).

A9. Inpatient share of contractual allowances and discounts (A7 X A8).

A10. Net inpatient revenue (A5 - A9).

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6.2000 continued

A11. Ratio of Medicaid/MediKan, State, and local government funds to net inpatient revenue (A4 /A10).

B1. Inpatient charity care charges, excluding Medicaid/MediKan, Medicare, contractual allowances and discounts.

B2. Other State and local government funds (A2 + A3).

B3. Ratio of inpatient revenues to total patient revenues (A7).

B4. Inpatient portion of State and local government funds (B2 X B3).

B5. Hospital costs from Medicare worksheet B Part I, total column, subtotal (line 95) - Rural Health Clinic (line 63) - Ambulance (line 64) - DME (lines 65 & 66) - Medicare (line 69) - unapproved teaching (line 70) - HHA (lines 71 through 81) - CORF (line 82) - HHA (lines 89 & 90) - ASC (line 92) - Hospice (line 93).

B6. Hospital revenue from Medicare worksheet G2, column 3, total patient revenue (line 25) - swing bed (lines 4 & 5) - SNF (line 6) - ICF (line 7) - LTCU (line 8) - HHA (line 19) - Ambulance (line 20) - CORF (line 21) - ASC (line 22) - Hospice (line 23).

B7. Cost to revenue ratio (B5 / B6).

B8. Hospital revenue attributable to the inpatient portion of State and local government funds (B4 / B7).

B9. Unduplicated charity care charges (B1 - B8. If this is negative, use 0).

B10. Ratio of unduplicated charity care to total inpatient revenue (B9 / A5).

C1. Low-Income utilization rate (A11 + B10).

D1, uninsured Charges. The uninsured are only those patients shown in charity care (B1) for which no other payment is received.

~~Payment Adjustment~~

~~If the low income utilization rate in C1 above exceeds 25%, then the excess over 25% shall be multiplied by 10 and the resulting number shall be multiplied by the amount of Kansas Medicaid/MediKan (excluding prior disproportionate share payments) payments for services received in the State Fiscal Year ending two~~

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~~years prior to the year of the administration of a disproportionate payment adjustment. For example 1993 state fiscal year payment adjustment shall be based upon state fiscal year 1991 Kansas Medicaid/MediKan annual payment.~~

An example of both the eligibility and payment adjustment computations are attached.

6.3000 Simultaneous Option 1 and Option 2 Eligibility

If a hospital is eligible under both 6.1000 and 6.2000, the disproportionate share payment adjustment shall be the greater of these two options.

6.4000 Request for Review

If a hospital is not determined eligible for disproportionate share payment adjustment according to 6.1000 or 6.2000, a hospital may request in writing a review of the determination within 30 days from the notification of the final payment adjustment amount. Any data supporting the redetermination of eligibility must be provided with the written request.

6.5000 Payment Limitations

If the payments determined exceed the allotment determined by HCFA in accordance with section 1923(f)(1)(C) of the Social Security Act, then all hospitals eligible for disproportionate share shall have their disproportionate share payments reduced by an equivalent percentage which will result in an aggregate payment equal to the allotment determined by HCFA.

All hospitals are limited to no more than the Kansas Medicaid inpatient portion of 100% of the cost of the uninsured plus the difference between the cost of the Kansas Medicaid inpatient services and the payments for Kansas Medicaid services. Data for both the uninsured and Medicaid cost and payments shall be based upon the Medicare cost report which must be available as of the start of the state fiscal year for which payments are to be made. The Kansas Medicaid inpatient portion is the ratio of Kansas Medicaid/MediKan inpatient days divided by total Medicaid/MediKan inpatient days. ~~Previous years data for both the uninsured and Medicaid cost and payments shall be used to estimate the limitation.~~ A cost determination of both the uninsured and the Kansas Medicaid inpatient costs shall be made upon receipt of an appropriate cost report.

~~If the hospital is a public hospital (State, city, county or district), then the payments determined above are further limited. Unless the hospital qualifies as a high DSH. Payments made during a fiscal year shall not exceed the cost incurred by a hospital for furnishing hospital services to Medicaid recipients less non-DSH and to uninsured patients less patient payments. In the case of a~~

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~~hospital with a high disproportionate share; payments made during a fiscal year shall not exceed 100% of the amount described above. To be considered a high DSH, a hospital must have a Medicaid inpatient utilization rate of at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State or have the largest number of Medicaid inpatient days of any hospital in the State in the previous fiscal year. Previous years data for both the uninsured and Medicaid cost and payments shall be used to estimate the limitation. A cost determination of both the uninsured and the Kansas Medicaid inpatient costs shall be made upon receipt of an appropriate cost report.~~

State of Kansas
Department of Social and Rehabilitation Services

Disproportionate Share Low-Income Utilization

All data on this schedule, except where specifically noted, should only include hospital inpatient data. Do not include SNF, ICF, long term care units, home health agency, swing bed, ambulance, durable medical equipment, CORF, ambulatory surgical center, hospice or non-reimbursable cost centers. Although specific line numbers from the Medicare Cost Reports are given, if blank lines on the Medicare Cost Report are used by the hospital, the blank lines should also be included or excluded, as appropriate, where there are similar references.

Hospital Name _____

Kansas Medicaid Number _____ **Fiscal Year Ending** _____

A1 Medicaid/Medikan inpatient payments for the most recent available hospital fiscal year, excluding disproportionate share payments. Contact AMS Fiscal (785-296-3981) for a log summary. _____

Other State and local government income. Provide source and description. Disproportionate share payments should not be included here. (Medicare Worksheet G-3, Governmental appropriations (Line 23))

A2 _____

A3 Total Medicaid/Medikan, State and local government funds. (A1 + A2) _____

A4 Inpatient Revenues (Medicare Worksheet G-2 Column 1, Total Inpatient Routine Care Services (Line 16) + Ancillary (Line 17) + Outpatient (Line 18) - Swing Bed (Line 4 & 5) - SNF (Line 6) - ICF (Line 7) - LTCU (Line 8)-other appropriate lines) _____

A5 Total patient revenues (Medicare Worksheet G-2, Line 25, Column 3) _____

A6 Ratio of inpatient revenues to total patient revenues (A4 ÷ A5) _____

A7 Contractual Allowances and discounts (Medicare Worksheet G-3, Line 2) _____

A8 Inpatient share of contractual allowances and discounts (A6 × A7) _____

A9 Net inpatient revenue (A4 -A) _____

A10 Ratio of Medicaid/Medikan, State, and local government funds to net inpatient revenue (A3 ÷ A9) _____

B1 Inpatient charity care charges. Charity care is considered to be any unpaid charge made directly to a patient where a reasonable effort has been made to collect the charge. This would include spendown incurred by a Medicaid recipient, the deductible on insured patients, and the entire charge of private pay patients, providing a reasonable attempt to collect the amount due has been made. This should also include the portion of any sliding fee scale which is not billed to the patient. It would not include any amount billed but not paid by a third party, such as Medicaid, Medikan, Medicare, or insurance (contractual allowance) or third party or employee discounts. Information to support this number must be maintained by the hospital and is subject to review. _____

B2 Other State and local government funds (A2) _____

B3 Ratio of inpatient revenues to total patient revenues (A6) _____

B4 Inpatient portion of State and local government funds (B2 × B3) _____

B5 Hospital costs (Medicare Worksheet B Part I, Total Column, Subtotal (Line 95)) - SNF (Line 34) - ICF (Line 35) - LTCU (Line 36) - Ambulance (Line 65) - DME (Line 66 & 67) - Medicare (Line 69) - Unapproved Teaching (Line 70) - HHA (Line 71 through 81) - CORF (Line 82) - HHA (Line 89 & 90) - ASC (Line 92) - Hospice (Line 93))

B6 Hospital revenue (Medicare Worksheet G2, Column3, Total Patient Revenue (Line 25) - Swing Bed (Line 4 & 5) - SNF (Line 6) - ICF (Line 7) - LTCU(Line 8) - HHA (Line 19) - Ambulance (Line 20) - CORF (Line 21) - ASC(Line 22) - Hospice (Line 23) _____

B7 Cost to revenue ratio (B5 ÷ B6) _____

B8 Hospital revenue attributable to the inpatient portion of State and local government funds (B4 ÷ B7) _____

B9 Unduplicated charity care charges (B1 - B8 (if negative use 0)) _____

B10 Ratio of unduplicated charity care to total inpatient revenue (B9 ÷ A4) _____

C1 Low-Income utilization rate (A10 + B10) _____

Section D only applies if C1 exceeds 0.25 and there is a minimum 1% Medicaid utilization.

D1 Hospital Limitation. All hospital are limited to no more than 100% of their net Medicaid cost plus the cost of the uninsured for FY 2000. The uninsured are only those patients shown in charity care (B1) for which no other payment is received. **Report the uninsured here.** Do not report Medicaid here. SRS shall compute the Medicaid limitation. This line must be completed by all hospitals or no disproportionate share payments will be made. _____

~~**D2** Estimated disproportionate share computation (Lessor of D1 or C3 x C4)~~ _____

D2	Cost of the uninsured (D1 x B7)	
D3	Loss on Inpatient Kansas Medicaid payments (Computed by Medicaid)	
D4	Subtotal of eligible losses (D2+D3)	
D5	Kansas Medicaid Inpatient Days in last available fiscal year of hospital	
D6	All Medicaid Inpatient Days in last available fiscal year of hospital	
D7	Kansas portion of Medicaid inpatient days (D5 ÷ D6)	
D8	Estimated Disproportionate Share Payments (D7 x D4)	

I declare that I have examined this statement, and to the best of my knowledge and belief, it is true, correct, complete, and in agreement with the books maintained by the facility. **I understand that the misrepresentation or falsification of any information set forth in this statement may be prosecuted under applicable Federal and/or State law.**

_____
Signature of Officer/Administrator

_____ _____
Title Date